Porter Medical Center

1. What are the hospital's goals for participation in payment reform initiatives in 2018 and in the next five years?
    a. What steps will the hospital take to meet these goals?

Answer: We have outlined our participation and commitment to payment and delivery system reform in our attached budget narrative.

2. As the hospital takes on financial risk, how is it planning to manage that risk while maintaining access to care, high quality care, and appropriate levels of utilization?
    a. How much money will the hospital be at risk for in FY18?
    b. What will happen if the hospital loses that money?
        i. How will the hospital fill in this gap, if necessary, without increasing rates?
    c. What will happen to the savings, if the hospital saves money?
        i. Will it go towards increased provider or executive salaries, lower commercial rates, community investments, or something else?
    d. Beyond the ACO-level quality measures, how will the hospital track access to care, utilization, and quality of care to ensure that new provider incentives do not have a negative impact on patient care?
        i. Please list the specific metrics the hospital will use.
        ii. For any metric(s) currently in use for this purpose, please provide results by year for 2014 to 2017 (to date).

Answer: Managing financial risk is not a something new to those in healthcare. We continually face the potential risk of changes in reimbursement, increased costs of care, and unanticipated changes in patient volumes. By managing our controllable costs and make the best use of our other revenue sources we are able to manage these risks.

These are the same methods that we will employ when it comes to managing the risks associated with the All-Payer Model. While there is risk involved in this model, there also comes more stability than in the current fee-for-service payment system as a result of the scheduled and more predictable payments. This will allow us to focus on providing the preventative services and care that will ultimately reduce the need for higher-acuity services. As we move toward a population health world this change will not only positively impact the health of our patients, but also reduce the costs of healthcare for all those involved.

Based on the OneCare budget estimate of $62 million in payments to Porter Medical Center in 2018, and the maximum risk exposure is $2.2 million. If we were to lose that money and not be able to offset it by managing our expenses, we would have to look at suppressing our planned capital investments. We will not compromise access to high-quality care.

Porter currently tracks 33 Quality metrics from both Press Ganey and One Care. Some examples of the Press Ganey metrics include those related to access (e.g. do you get an appointment as soon as you want) and Quality (e.g. overall provider rating). Additionally, we are measuring items such as cancer prevention screenings, depression screenings, diabetes control screening, as well as chronic disease management.

Comparison of Vermont Commercial and Medicaid ACO Shared Savings Program Measures for 2015 and 2016 with Year 3 Medicare ACO Shared Savings Program Measures

Key: Y=Yes; N=No; C=Claims; MR=Medical Record; S=Survey; R=Reporting; P=Payment

Measure Description	Blueprint for Health Pay for Performance Measures	Data: Claims, Medical Record, or Survey?	Medicare SSP Use Year 3	Commercial SSP Use Year 2 (2015-2016)	Medicaid SSP Use Year 2 (2015-16)	Improvement from 2014-2015
Risk-Standardized All Condition Readmission		C	P			
Ambulatory Sensitive Conditions Admissions: COPD		C	P	R	R	
Ambulatory Sensitive Conditions Admissions: Heart		C	P			
30-Day All-Cause Skilled Nursing Facility		C	R			
All-Cause Unplanned Readmissions for People w/ Diabetes		C	R			
All-Cause Unplanned Readmissions for People w/ Heart Failure		C	R			
All-Cause Unplanned Readmissions for People w/ Multiple Chronic Conditions		C	R			
Depression Remission at 12 Months		MR	R			N
% of PCPs who Successfully Qualify for an EHR		Other	P			
Documentation of Current Medications in the Medical Record		MR	R			same
Falls: Screening for Future Fall Risk		MR	P			Y (80th)
Influenza Immunization		MR	P			Y (80th)
Pneumococcal Vaccination for Patients 65 and Older		MR	P			Y (80th)
Adult BMI Screening and Follow-Up		MR	P	R	R	N (60th)
Tobacco Use: Screening and Cessation Intervention		MR	P	R	R	same (90th)
Screening for Clinical Depression and Follow-Up Plan		MR	P	R	R	N (0)
Colorectal Cancer Screening		MR	P	R	R	same (60th)
Breast Cancer Screening		C	P			same (60th)
Diabetes Eye Exam (Composite)		MR	R	R	R	Composite
Diabetes HbA1c poor control (Stand-	P	MR	R	P/R	P/R	Composite
Hypertension: Controlling High Blood Pressure		MR	P	P	P	N (50th)
Proportion of Adults who had Blood Pressure		MR	P			Yes (90th)
IVD: Use of Aspirin or Another Antithrombotic		MR	P			N (80th)
Heart Failure: Beta Blocker Therapy for LVSD		MR	P			N (70th)
ACE Inhibitor or ARB Therapy for Patients with CAD and Diabetes and/or LVSD		MR	R			N (below 30th)
All-Cause Readmission		C		P	P	
Adolescent Well-Care Visit	P	C		P	P	Y
Follow-Up After Hospitalization for Mental Illness (7 day)		C		P	P	
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment		C		P	P	
Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis		C		P	P	
Chlamydia Screening in Women		C		P	P	
Developmental Screening in First 3 Years of Life	P	C		R	P	Y
Rate of Hospitalization for Ambulatory Care-Sensitive Conditions: PQI Composite	P	C		P	P	
Appropriate Testing for Children With Pharyngitis		C		R	R	
Childhood Immunization Status		MR		R	R	Y (90th)
Pediatric Weight Assessment and Counseling		MR		R	R	N (75th)
Cervical Cancer Screening		MR		R	R	N (below 25th)
NCQA Patient-Centered Medical Home Recognition	P					
Patient Experience Surveys						
Patient Experience: Getting Timely Care		S	P			
Patient Experience: How Well Providers		S	P			
Patient Experience: Patients' Rating of Provider		S	P			
Patient Experience: Access to Specialists		S	P			
Patient Experience: Health Promotion and Education		S	P			
Patient Experience: Shared Decision Making		S	P			
Patient Experience: Health Status/Functional Status		S	R			
Patient Experience: Stewardship of Patient		S	R			
PCMH Patient Experience: Access to Care		S*		R	R	
PCMH Patient Experience: Communication		S*		R	R	
PCMH Patient Experience: Shared Decision-Making		S*		R	R	
PCMH Patient Experience: Self-Management Support		S*		R	R	
PCMH Patient Experience: Comprehensiveness		S*		R	R	
PCMH Patient Experience: Office Staff		S*		R	R	
PCMH Patient Experience: Information		S*		R	R	
PCMH Patient Experience: Coordination of Care		S*		R	R	
PCMH Patient Experience: Specialist Care		S*		R	R	
PCMH Patient Experience: DLTSS Services		S*		R	R	

*The same survey is used in Vermont to provide practice-level results and ACO-level results. Implementation of the survey by a certified vendor is coordinated and financed by the State, using SIM and DVHA funds.

3. Does the hospital participate in any capitated payment agreements directly with insurers? If yes, please describe:

a. Whether the capitated payments save the insurer money compared to fee for service payments;

b. Whether the hospital and/or its providers earn more profit under capitated payments or fee for service, on average;

c. How the hospital ensures that patients continue to receive appropriate services under capitated payments.

Answer: In December of 2016, Porter Hospital made the decision to enter into our first risk based contract with Medicaid under the Vermont Medicaid Next Generation program. We are the first Critical Access hospital in Vermont to participate in payment reform and we are committed to being a Critical Access leader in the transition to a value based model. We are still evaluating the success of the program and will need this full first year as a measurement period to adequately account for our results.

The goal of the all payer model is to promote and encourage the delivery of the right care at the right time in the right setting.

4. Please describe the financial incentives that the hospital currently includes in provider, coder, and other personnel salaries and/or contracts.

a. How has the use of incentives by the hospital changed over time?

Answer: During the course of FY 2017, Porter has moved many of its provider groups from salary based contracts, to performance based compensation models with bonus opportunities. These plans include a base salary amount and the opportunity to earn additional compensation based on the following key performance indicators:

Productivity – calculated based on earned wRVUs (worked relative value units) that are benchmarked against data for their specialty from the MGMA (Medical Group Management Association) Survey.

Quality – Metrics are determined based on the categories of Patient Satisfaction, Citizenship, Quality Improvement, and Access. Each provider group is collaborating with leadership to determine the best metrics for their specialty.

Other – Primary Care Providers have the opportunity to receive additional compensation for their patient panel size as well as their participation in the MAT (Medication-Assisted Treatment, Suboxone) program.

In the future, as we navigate through payment reform and move toward a more capitated payment structure; we envision embracing a more quality-centric compensation model.

5. Does the hospital or any of its departments or personnel receive financial or other benefits for using specific pharmaceuticals?

a. Please list all pharmaceuticals for which the hospital or provider receives payment when the drug is prescribed, administered, and/or when the prescription is filled.

Answer: No.

6. With the various payment reform initiatives underway, shared decision-making is becoming increasingly important as an antidote to the potentially perverse incentives of risk-based payment models.

a. Do you commit to implementing shared decision-making throughout your hospital system in 2018?

b. Please describe your plan for doing so and how you will measure the plan's implementation progress.

Answer: Porter Hospital supports the shared decision-making model and is committed to expanding this design during FY 2018. We have laid the foundation to build upon model in FY 2017 with the following initiatives:

We have established a Patient Experience Committee (PXC) with patient and clinical representation that convenes monthly. At the recommendation of this committee, Porter engaged a consultant for three months to incorporate an organizational-wide program that emphasized the importance of a patient-centric approach to every interaction, across all functions of the organization (referred to as the "Service Excellence" program). We have included the continuance of this program in our FY 2018 budget. Departments are held accountable for following the precepts of this program to ensure ongoing success. We will utilize our Press Ganey scores to evaluate our success over the coming year.

Porter is creating a Patient and Family Advisory Council and our goal is to interview and choose 10-15 members to make up this council during the 2018 fiscal year.

Last year we formally created a Case Management Director position to oversee our existing Case Management Department; whose job includes care coordination, improving transitions of care, and making sure that patient and family voices are heard. In 2018, the collaboration between this department and our ACO/Blueprint Complex Care Coordination program will expand. Care coordinators across our organization are meeting biweekly with representatives from multiple community agencies including the Parent-Child Center, Age Well (AAA), Addison County Home Health and Hospice, CSAC (Counseling Service of Addison County), the Turning Point Center of Addison County, and many others. One of our measures of success will be achieving a 50% enrollment in Care Navigator, which is the shared decision-making program developed by OneCare for our highest-risk Medicaid Next Gen population.

7. What is the extent of your Choosing Wisely initiative(s), if any? Please describe the initiative(s), how you have chosen which departments participate, and which of these initiatives, if any, have led to identifiable cost savings and/or quality improvement.

Answer: Over the course of the last year, Porter has participated in the following cost-saving processes and has engaged in a number of specific "Choosing Wisely"- type initiatives.

Current Initiatives:

- Automation of Inventory in the OR using hand held devices for accuracy and efficiency, which eliminates overtime.
- In our Surgical Services department we have developed a database and system for tray tracking (implants, screws, etc.).

- In our Medical Surgical department, we have organized supply closets and added a color coding system to make it quick for nurses to access medical supplies. This eliminates product waste, creates operational efficiencies, and prevents the expiration of products.
- Established inventory par levels across the organization, which are monitored regularly by materials management. Although currently, this is a manual process.
- Implemented a reprocessing program in our Surgical Services department.

Upcoming New Initiatives:

- Establish electronic pars for all OR inventory, implants, etc. which will eliminate excess inventory, create operational efficiencies, and prevent expired product.
- Develop auto-ordering and electronic requisitioning for departments.
- Order supplies based on the procedure, rather than keeping stock on hand at all times in OR.
- Implement a color coding system in the Emergency and Labor and Delivery department.
- Automate the ordering of supplies in the laboratory.
- Set up pars within the ED procedure rooms to eliminate waste due to product expiration and excess inventory.
- Eliminate the need for overnight/urgent shipments of supplies in our Surgical Services department.

8. Please provide copies of your financial assistance policy, application, and plain language summary as well as detailed information about the ways in which these three items can be obtained by patients.

a. Please provide the following data by year, 2014 to 2017 (to date):
i. Number of people who were screened for financial assistance eligibility;
ii. Number of people who applied for financial assistance;
iii. Number of people who were granted financial assistance by level of financial assistance received;
iv. Number of people who were denied by reason for denial.

Answer: Porter Hospital's Financial Assistance Policy, plain language summary, and application are attached as requested.

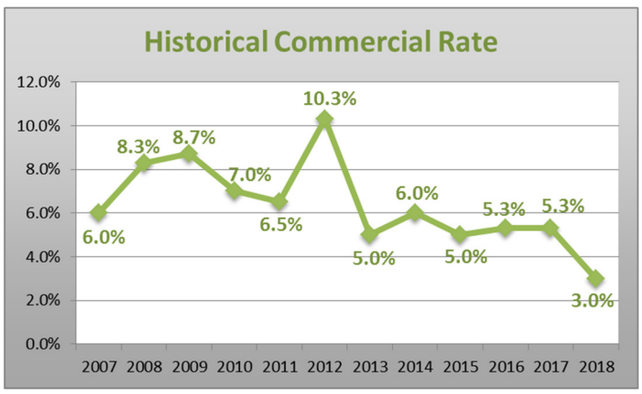
Porter Hospital is committed to improving the health of our community one patient at a time regardless of their financial situation.

PMC Financial Assistance Program	FY 2014 Actual	FY 2015 Actual	FY 2016 Actual	FY 2017 YTD July	Grand Total
APPLICATIONS					
Total Applications	732	583	676	682	2,673
Total Household Members	1,336	1,052	1,215	1,152	4,755
APPROVED/GRANTED					
20%	22	13	22	22	79
40%	29	42	54	50	175
60%	46	51	43	48	188
80%	98	79	96	78	351
100%	393	320	367	369	1,449
APPROVED/GRANTED Total	**588**	**505**	**582**	**567**	**2,242**
DENIED					
Over Income/Assets	40	36	40	56	172
Insufficient Application Information Received	104	42	54	31	231
DENIED Total	**144**	**78**	**94**	**87**	**403**
OPEN APPLICATIONS	**-**	**-**	**-**	**28**	**28**

9. As a nonprofit with a duty to benefit the community, how does the hospital ensure that its commercial rates are in the best interest of consumers? Please provide specific metric(s) that the hospital uses to determine this. For any metric(s) currently in use for this purpose, please provide results by year for 2014 to 2017 (to date).

Answer: Porter Hospital provides community benefits to our communities in many ways, as reflected in Schedule H of the IRS Form 990. In FY 2016, Porter Hospital's community benefit totaled $3.9M, or 5.2% of its total expenses.

As it pertains to our commercial rates, the 3% rate increase represents the lowest increase in over ten years:



This is a significant decline from the commercial rates submitted prior to 2013 and reflects our continued commitment to control expenses while meeting the needs of our community, fulling our mission, and make investments in healthcare reform.

10. We often hear from hospitals that they charge extra for a wide variety of services in order to fund core hospital services. In light of this business model, how does the hospital ensure that the prices of its services are set appropriately?

a. What factors are considered in setting prices?

b. What financial or quantitative metrics does the hospital use to ensure that its service pricing is appropriate? For any metric(s) currently in use for this purpose, please provide results by year for 2014 to 2017 (to date).

Answer: Hospitals are required to provide a wide range of services to the community regardless of the patient's financial situation. Costs for many of these services can significantly exceed the amounts paid to the organization by Federal payers and uninsured patients. As noted in response to question 9, Hospitals provide community benefit for the communities that they serve. One component of that benefit is providing care to patients who are unable to pay. Porter provided a total of $631 thousand (in cost, not charges) in charity care to patients who qualified under our financial assistance plan.

In order to ensure the core hospital services the community relies upon can continue to be provided, and that the hospital can remain a vital safety net for the community, the price differential is often shifted to commercial insurance companies in their negotiated rates (what is commonly referred to as the "cost shift"). Hospitals must consider the following factors when ensuring the appropriateness of the total revenue necessary to continue to serve their communities and meet their missions: the cost of performing services and procedures, including any market increases expected in the cost of pharmaceuticals and medical devices, historical and/or anticipated volume, marketability, anticipated government payer reductions, and any related strategic initiatives.

Porter periodically evaluates the hospital's chargemaster to see if charges are in alignment with peer benchmarks and has in the past several years engaged an outside vendor to ensure the appropriateness of our alignment.

11. For the hospital's inpatient services, please provide your all-payer case mix index, number of discharges, and cost per discharge for 2014 (actual) through the present (2017 budget and projected) and 2018 (budget).

Answer: We have responded below with adjusted admissions in lieu of discharges as cost per discharge is not a standard industry benchmark. Additionally, we do not have the ability to isolate inpatient expenses.

	FY 2014 Actual	FY 2015 Actual	FY 2016 Actual	FY 2017 Budget	FY 2017 Projected	FY 2018 Budget
CASE MIX INDEX						
CMI	1.0314	1.0252	1.1195	1.1202	1.1332	1.1641
ADMISSIONS						
Adjusted Admissions	6,515	6,362	6,209	6,226	6,199	6,311
Cost Per Adjusted Admission	$ 11,006	$ 11,791	$ 12,172	$ 12,420	$ 12,755	$ 12,844